RECONSTRUCTION IN THE PRACTICE OF MEDICINE

Harveian oration for 1941 *of the Royal College of Physicians of London*

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RECONSTRUCTION IN THE PRACTICE OF MEDICINE

THE privilege of delivering this oration within the walls of the college has been denied to me, as to my immediate predecessor in this office, owing to destructive forces from which our home, like many others, has not entirely escaped. It is not unnatural that, pending its organic restoration, our thoughts should be busy with replanning the functional activities of our profession in the world outside. At a moment when it seems we are faced with the imposition or the adoption of a new order in the practice of medicine it may not be unprofitable to ask of ourselves whether and why we admit a need for changes.

To the first question there is but one answer. Those of us who have been studying and practising medicine for half a century are probably as ready to admit or even to assert this need as the student or lately qualified practitioner of today. In fact, there is general agreement that the profession, as at present organised, is not giving the public the best service of which it is capable—allowing that there may be some differences of opinion in regard to the origin and nature of its shortcomings. If, then, we admit that the practice of medicine is ailing we, as physicians, should study its past history, the changes which have taken place in its environment, and the symptoms from which it is now suffering, before venturing to prescribe any form of treatment. As physicians too we shall be prepared and not surprised to see our prescription disregarded and our prognosis falsified !

There are a number of considerations which must influence our judgment of the past and our advice for the future. We must remember, for instance, that although the practice of medicine, in some form or other, is of great antiquity, the present variety, characterised by its struggle for scientific status, is but a child and still in need of guidance and education. Its attributes, inherent or acquired, good, bad or indifferent, are plain to see and it should not be beyond our powers so to fashion its adolescence that in its maturity it may satisfy the just needs of the community. Nor must we forget that the practice of medicine is only one of many social services the evolution of which is being materially affected by rapid changes in the classic and economic fabric of our time and country. Medical isolationism is neither possible nor desirable.

In the course of any evolutionary process, notably in the cultivation of the tree of knowledge, branches are apt to pass through phases of rich growth and expansion

with the result that we are in danger of regarding them as distinct plants and to forget the ultimate purposes which they share with kindred offshoots. While we are reconciled to these natural phenomena and are satisfied that real progress is largely dependent on them, it is incumbent on us to watch their steps and, at the appropriate moment, to guide them towards their common goal.

In the last hundred years, particularly in the last seventy, we have seen examples of remarkable growth in each of the two main branches of the practice of medicine, the remedial and the preventive ; each has become increasingly specialised and distinct from the other ; each requires separate review before determining what is to be their future relationship and whether the time is ripe for more coördination and control.

Remedial Medicine

Remedial medicine, better known as medical practice, whether carried out in private or institutional surroundings, has undergone many changes in the last seventy years, largely owing to the rapid advance of medical skill and knowledge. The first half of that period, roughly speaking, was one of exceptional progress in the doctor's use of his innate senses, sight, hearing and touch, in the diagnosis of disease and in his powers of observation and deduction, both at the bedside and in the post-mortem room. Careful observations and accurate records attained high standards while the influence exercised by the natural sciences was still in its early stages. Except for the exploitation of antisepsis and asepsis in the field of surgery treatment made no great advances. At the same time much knowledge was accumulated in regard to the origin, natural history and classification of pathological processes.

Then followed an era when the ancillary sciences, especially those of physics and chemistry, conspired to supply the doctor with many important additions to his equipment for both diagnosis and treatment. The discovery of X rays and radium, the large increase of work undertaken by clinical, bacteriological and biochemical laboratories and the recent rapid advances in physio- and chemo-therapy are only a few examples of the scientific mechanization of medical practice in later days.

In a few words the ancillary sciences have, in the course of forty or fifty years, changed the whole aspect of medical practice and, what is still more important to realise, have poured into the minds and hands of the profession a mass of new knowledge and new equipment which they were ill prepared and ill organised to use for the universal benefit of the public. Even if we claim, as undoubtedly we can, that very creditable efforts

have been made to meet this situation we must admit an urgent need for the reorganisation of our ranks and our resources. Perhaps I should have said organisation rather than reorganisation because evidence of the former has been little enough during this period of rapid progress, when rivalry and competition, personal and institutional, have had almost unlimited free play. Such a period was probably necessary and even desirable for a successful campaign against disease, but should it not be followed by some consolidation of our gains and some redistribution of our forces before venturing on further conquests ?

INTRINSIC DIFFICULTIES

What are the chief difficulties in the path of satisfactory medical practice today ? I should have little hesitation in placing first among these the factor of " time." May I quote a few passages of my own, written five years ago ?

" It is probably true to say that the time factor is not yet popularly recognized as the most important ingredient of efficient medical practice, and that every addition to the store of medical knowledge enhances its value. The more possibilities open to the mind of the doctor, the more paths of enquiry he is obliged to pursue ; the more evidence there is collected to be weighed, the longer is the time he needs to do justice to his patient. The not uncommon belief that the speed with which a doctor arrives at a diagnosis is an indication of his professional ability rather than of his business capacity cannot be seriously supported, and even if it may be to some extent justified when a case of fully developed disease is placed before him it lacks all foundation when he is confronted with what are known as minor ailments. If the standard of health of the community is to be raised it can only be by the earliest possible detection of slight departures from normal health and by the prompt initiation of measures for their arrest. It is at this stage that recognition of illness is most urgent and fruitful, and it is then, far more than later, that the doctor requires time to bring all his knowledge and all his technical resources into action. Both oral and physical examinations of the patient involve expenditure of time, and in most cases the former is the more lengthy as well as the more enlightening piece of research if skilfully pursued . . .

" Any medical service which aims at the prevention and early detection of disease, to say nothing of the preservation of health, must provide the doctor with ample time to carry out his work, and, I have no hesitation in adding, the better educated the doctor the more time he will require. The chief flaw in a badly organised service, such as that which has evolved in this country during the last century, is lack of time, and both the general practitioner and the consultant, in order to earn a living wage, are frequently obliged to undertake far more work than they can deal with efficiently in the hours at their disposal . . .

"That, in a word, is the problem before us, and if the community cannot afford to support a hundred thousand instead of fifty thousand doctors—and you will readily agree that it cannot—every effort should be made to ensure that time and energy, as well as money, are not wasted in any system of service we are engaged in developing."

If this general principle is accepted, and I cannot admit that it is controversial, it must be applied much in the same way to institutions as it is to individual doctors. The crying scandal of long lists of patients waiting for admission is an indictment of our hospital system, indicating, as it does, that the guilty institution has not the requisite time to perform its proper functions and that either an increase of accommodation and staff or a redistribution of its clients is urgently needed. How long will the public tolerate these lengthy waiting-lists and, indeed, how long will it put up with the hours of waiting for attention in the outpatient departments of all large hospitals ?

OUTSIDE INFLUENCES

And these questions lead naturally from the consideration of the intrinsic difficulties of medical practice to those which are exerting their influence from outside, from the changing social and economic circumstances of the population which the profession has to serve. During the period which I have under review there has been a rapidly spreading tendency on the part of all classes of society to seek help from hospitals in times of sickness or injury and to expect such help in return for smaller or larger payments or contributions. The purely charitable basis on which many of our hospitals were founded and long maintained is fast disappearing in practice and few of them could carry on today without the financial support of their patients.

The reasons for this great change are not far to seek. With the advance of medical knowledge to which I have referred modern methods of diagnosis and treatment have become so much more intrinsically expensive and so much more dependent on specialised skill in their application that many of them are not available except in institutions. On economic grounds alone this must continue and any new scheme of hospital service must provide for the accommodation and treatment of patients varying over a wide range of income. And if further argument were necessary we have only to remind ourselves that social and domestic conditions permit few households to stand the strain of long illnesses and skilled nursing at home. Assuming then that the investigation of obscure cases of illness and that the medical and surgical treatment of many patients who are seriously ill or injured will become increasingly recognised as the functions of the hospitals, we are

obliged to anticipate a change in the scope and character of general practice. That this may not be in complete harmony with the present rôle and source of livelihood of the general practitioner is true enough, but it can hardly be doubted that, for the purposes referred to, members of the public are better off in specially equipped and specially staffed institutions, even if, for a time, they cease to be under the direct control of their own doctors. This point will be further elaborated at a later stage but before leaving the question of medical practice a few words must be devoted to one aspect of it which cannot be very far from the thoughts of all of us and which presents a very difficult problem.

I refer to the custom, of very long standing, in accordance with which a large proportion of practitioners depend for a great part of their incomes on patients whom they attend on a fee-per-visit basis. While this principle, so easily open to abuse, has been carried out in general with great fairness and honesty it remains fundamentally wrong in that it discourages that intimate relationship between patient and doctor whereby the latter should be the guardian of the former's health. It is impossible to argue that such a system is anything but an obstacle in the path of public health and of preventive medicine. The preservation of health and the prevention of disease, in themselves of far greater interest to the welfare of the community as a whole than remedial medicine, should be, but are far from being, the chief concerns of the general practitioner in his client's home.

If National Health Insurance was established by the state with the intention of giving the manual workers of the country the advantage of medical service without fees and of so encouraging them to consult their doctors as the protagonists of their health as well as the alleviators of their suffering, the result has not fulfilled expectations. Too large panels are fatal obstacles and the separation of wage-earners from their dependants in the scheme of benefits makes it even more difficult for panel practitioners to play the part of priests of preventive medicine in the homes of their patients. Nor did the scheme afford the practitioner ready access to skilled methods and skilled advice for the early recognition of ill health in his clientele.

It is easier to expose the evils of practice based on the fee-per-visit system and to show how the National Health Insurance scheme has so far failed to overcome them than it is to suggest an improvement. On the other hand, it is difficult to avoid the conviction that in some form of comprehensive, well-organised and perhaps compulsory insurance lies the solution of this old and elusive problem.

Preventive Medicine

The other great branch of practice, that of public health and preventive medicine, also is a child, less than

a century old, but a child of the state. It, too, exhibits precocities of growth and promise of further development. It has already accomplished much in its fight against slums, dirt, infection and industrial disease. It has done much indeed for the health of mothers and children. In short, the history of our public health services is one of which our country may be justly proud. Those of us who worked in the outpatient departments of great city hospitals at the end of the last and the beginning of the present century are best able to appreciate the amazing improvement in habits, behaviour, cleanliness and nutrition which is to be found in the denizens of those departments today, and which can be credited very largely to the progressive policy of some of our governments and of some of our local authorities.

So far, so good, but can we be satisfied that the way is wide open for further advance ? The servants of the state and the local authorities have reached the outer defences of the home but their good influence has not yet really passed its threshold. And can further progress be made unless the coöperation of the general practitioner within the home is enlisted ? Provision for environmental hygiene has been developed along sound lines but its efficacy has been largely discounted by inadequate alliance with the general practitioner who should be responsible for personal hygiene if we are to see great strides made towards the attainment and maintenance of good health by the public.

It is easy to be wise after the event, but looking back one is forced to the conclusion that the establishment of panel practice, without radical changes in the medical curriculum, was an ill-advised step and has proved an obstacle in the path of preventive medicine. At the present time we have on the one hand the great bulk of the profession subsidised to combat established ill-health without the modern equipment necessary for the purpose, and, on the other hand, a smaller number of whole-time officers paid to preserve the health of the community but without the personal and domiciliary contacts essential for the success of their tasks. And this schism of interests is likely to persist, interfering with the progress of preventive medicine and of public health, unless measures are taken to deal with the faults at their source. And what are the faults ?

THREE BASIC DEFECTS

In the first place a man who goes into panel practice has received little instruction in the subjects of the preservation of health and of the prevention of disease. His attention has been directed almost entirely to the diagnosis and treatment of disease, and mainly of established disease, rather than of early and slight departures from health.

In the second place under the prevailing organisation the panel practitioner has not the time nor the facilities to devote to his chief objectives, the preservation of health, the prevention and the early diagnosis of disease, even if his previous training had been directed to that end.

In the third place the whole subject of Social Medicine has been, and is being, neglected in this country. While it is true that great strides have been and are being made in the fight against a number of serious ailments as the result of work in laboratories of pathology, biochemistry, pharmacology, bacteriology and physiology, the time has come for an organised investigation of the social factors in many obscure ætiological problems by a force of doctors specially trained for the purpose.

The results obtained in the field of industrial diseases suggest a wider scope for similar inquiries into the origin of many other disabilities. Is it not possible for instance that the key to the ætiology of such common diseases as the various forms of rheumatism and the septic ulcer may be found in the social field ? It is a welcome sign of progress that field work in relation to the nutrition of the population has been stimulated by the present national emergency and in so doing affords a good example of how the laboratory worker and the clinician can combine to attack an obscure problem from at least two angles. Let us hope that such examples may be more generally followed and that the divorce between the research laboratory and the ward, arising more from diversity of environment and atmosphere than from any one-sided monopoly of talent, may be completely rescinded.

AND THEIR ERADICATION

If the basic defects in our professional organisation have been sketchily but truthfully indicated we may consider the principles which should govern the process of their eradication. It would seem that there are three main branches of professional activity each of which, however well defined, should work in close accord with the others.

The first branch is that of environmental hygiene and preventive medicine, the field allotted by necessity to medical officers of health who have legal authority for many of the measures they take in order to accomplish their task. These officers require, and do in fact receive, special postgraduate training for their preventive work.

The second branch is that of personal hygiene, including preservation of health, the early detection and diagnosis of ill health and the care of patients suffering from the lesser and more chronic disabilities. These are the special and important prerogatives of the general practitioner. For this career there is no adequate training provided and little organised collaboration with the public-health branch.

The third branch includes curative medicine, teaching and research, which come within the range of the specialised and academic departments of institutions. The preparation for careers in these subjects is fairly adequate, but liaison with the general practitioner branch is still imperfectly defined and organised.

To these three branches of professional activity I would hope to see added in the near future one of social medicine. It would need to be developed on experimental lines, perhaps by the establishment of two or three departments for the purpose in universities with medical schools. In time these would, I am confident, contribute much to the efficiency of the other three branches. At the moment there would seem to be few members of the profession specially trained for the promotion of social medicine and no schools available to meet the demand. I do not hesitate to submit that steps to overcome this gap in our resources are among the most urgent needs of the immediate future, in the interests of the public and of the profession.

Reconstruction

We may now turn to the subject of reconstruction, fully recognising that this process must be carried out gradually, that the structure we are designing must be raised on well-chosen and well-considered foundations and that in its erection old material which has proved its worth may well be utilised.

Starting with the assumption that some measure of postgraduate training is desirable for every duly qualified practitioner, whether he enters the field of general practice, of public health, of consulting practice, of social medicine or of teaching and research, it is obviously desirable to decide what kind of education should be common to all students seeking to enter the medical profession. Considering the dissatisfaction, almost universally expressed, with the general education of the medical student, it is surprising to find that there is still no effective collaboration between secondary schools and universities in this country, no authoritative body endowed with the responsibility of planning an agreed scheme of preparation for the learned professions.

Were an authoritative body in existence it would, I venture to think, make some such recommendations as the following for prospective medical students:—

(1) That education at school until 18 years of age should be of a general character, including a measure of instruction in biology, chemistry and physics such as every boy and girl has a right to demand, whatever is to be his or her career in life. This would allow time to acquire some degree of proficiency in the English, and at least one or two other, modern languages, and would do away with the curse of early specialisation.

(2) That entry to university medical schools, by scholarships or otherwise, should be gained by general merit and intelligence, judged by examinations and by school reports on the candidates' fitness for a medical career. Such a step would again discourage early specialisation and would give the medical student a wider cultural background than is possible in most instances today.

Medical education would then begin in the medical school which would have as its primary object the training of students for a basic qualification to enter the profession, on the understanding that further preparation would be necessary for each of its main branches of practice. This medical curriculum naturally divides itself, although the division should not be too rigid, into preclinical and clinical phases, and the former is ripe for critical reconsideration.

PRECLINICAL EDUCATION

Leaving aside any period devoted voluntarily to the advanced study of some scientific subject, such as physiology, anatomy, biochemistry, embryology, or pharmacology, the preclinical stage should occupy 3 years. During that time the student should acquire a general knowledge of human biology and for that purpose it should be possible to devise an integrated course of instruction unspoilt and uncomplicated by traditional conventions. Such a syllabus could and should avoid many anomalies which only serve to confuse the student's mind and to damp his natural interest in his work. Why, he may ask, should I study the gross anatomy of an organ, its minute structure and functions, in different departments and at different times ? The aim of the syllabus should be to gain for the student an understanding of man as a living animal, of the principles governing his heredity and reproduction, of his growth, nutrition and development, and of the forces underlying his mental and physical activities and his reactions to his environment.

In supplying the student with this knowledge it is necessary to utilise animals lower than man and thus " to exhort him to search and study out the secrets of nature by way of experiment." At the same time there is much in human biology which can be best illustrated by observations on living man, both healthy and unhealthy, and much more use should be made of patients during this stage of the curriculum. It may well be that the importance of exercising the faculty of discrimination in medical education is inadequately recognised and that the student's memory, critical judgment and interest would be reinforced by affording him every opportunity of comparing the normal with the abnormal in human structure and function. In addition to the intrinsic value of such exercises they serve to break down the artificial barriers dividing the curriculum into a number

of watertight compartments and to give the student a sense of reasonable and reasoned continuity in his education which is now lacking.

This is not the moment for attempting a detailed reconstruction of the preclinical syllabus but it would not be out of place to suggest that time could be spared from the hours spent in dissecting the whole body, for instance, and devoted to the study of elementary sociology and psychology. It is impossible to appreciate the problems of human life without some acquaintance with man's normal and abnormal reactions to his physical and personal environment, and the earlier the student is introduced to this important aspect of his future work the better prepared will he be to understand the significance of health and disease when he enters his hospital world.

CLINICAL EDUCATION

During the next 3 years the student's attention is largely concentrated on the study of human pathology. He needs, at the beginning, to become familiar with the fundamental principles of general pathology and bacteriology, and throughout this period to reinforce that acquaintance by observations in the laboratory and post-mortem room as well as at the bedside. The natural history of disease and the recognition of its early signs are subjects on which emphasis is naturally laid by his teachers who, for the most part, have chosen diagnostic and remedial medicine as their particular branch of the profession. This is only right and proper ; but, in the interests of the majority of students, who are destined for general practice or public health work, more of their energy and time than has been hitherto the case should be devoted to other aspects of their future work. In all recent attempts to review and revise the medical curriculum stress has been laid on such defects as the lack of attention to preventive measures, to the relative paucity of facilities for the study of minor ailments and to the need for more systematic instruction in psychological medicine. There is room, perhaps, for a larger and more varied panel of teachers and a reconsideration of their responsibilities. Greater use, too, might be made of other health and social services and of other institutions for that purpose. It may be that such changes, which are generally agreed to be desirable in the clinical phase of the curriculum, will not be carried out until alterations are made in the status, appointment and duties of the teaching staffs of medical schools and until the cöordination of hospital services has come into effect.

It is unnecessary to elaborate further the reform of the clinical period of the curriculum if its essential purpose, the preparation for a basic qualification common to all branches of the profession, is kept in mind. In

laying out this field of reconstruction there is ample scope for weeding as well as for sowing and planting.

APPRENTICESHIP

Following the successful passage of the examination required for a basic qualification the student is faced by a choice of several careers for each of which a further period of apprenticeship, of varying length, should be an obligation.

For those who look forward to the remedial and academic branches of our profession the apprenticeship is already fairly defined. It may be summarily described as a long and laborious ascent of the institutional ladder sufficiently subsidised, as one would hope, for all to attempt who are otherwise adequately equipped for the higher rungs.

For those who look to general practice for their livelihood apprenticeship should be less prolonged and might well be divided between a resident appointment in a hospital and a short period of attachment to a department of social medicine or to one of the social services.

For those entering the public health service a somewhat lengthier apprenticeship on similar lines leading up to the attainment of a diploma might well be devised.

General Considerations

There has now been submitted, in skeletal form and obviously capable of modification, a plan for the reconstruction of medical practice which requires for its execution some readjustment of long-standing conceptions and conventions. Such readjustment is in some instances desirable and in others probably inevitable. In examining this plan and its implications we may start with three assumptions :

(*a*) that the preservation of health and the prevention of disability in a community are the highest aims of a medical service whether looked at from the humane or from the economic point of view ;

(*b*) that the state, in its response to the demand for social services, will not only make increasing provision for the fulfilment of these aims, but will acknowledge the claim of every member of the community when disabled, whatever his means, to the best that the medical profession can offer for his restoration to health ;

(*c*) that in cases of serious disability skilled diagnosis and treatment must pass more and more into the hands of specialists and hospitals.

EFFECT ON GENERAL PRACTICE

We may now consider the implication of the plan I have submitted on general practice and how the latter

is affected by the three assumptions. I would suggest that, in the future, with the training I have described and with easy access to skilled help in diagnosis and treatment for his patients, when necessary, the general practitioner would be better equipped to perform his primary duties. He would be qualified too to advise his clients on such questions of personal hygiene, genetics and nutrition as affect the well-being of the family. In the prevention and early detection of departures from good health he would find a greater interest and more satisfying results than he would as the doctor whose help is only called upon when ill health has established a footing in the home. If he were so minded he could contribute largely to the advance of medicine in the little explored fields of social medicine and in many instances would be encouraged to take a part in public health activities and clinics. In some districts hospital appointments would be open to him by means of which he would be in a position to increase both his therapeutic skill and his income.

In order to secure a career as attractive as this certain conditions are essential. The problem of adequate time for the efficient discharge of his duties, a subject to which I have already referred, must be solved by the limitation of his clientele, by ceasing to look for his livelihood to patients by whom he is paid per visit, by ample provision of hospital accommodation and specialists within his reach and perhaps by sharing essential offices and other services with other practitioners.

But beyond and above all these essentials there is another of even greater importance. The attitude of the public towards health and disease, although more enlightened than it was twenty or thirty years ago is still far from helpful or satisfactory. There remains more than a suspicion in many minds that illness is an act of God, something which is inevitable and dependent more on bad fortune than on neglect or ignorance. The public is not yet alive to the advance of scientific medicine and to the light which has, in recent years, been thrown on the dark places of ætiology and pathology. Speaking generally, they are far more concerned with cure than with prevention. It is a change in this attitude which is essential for the general practitioner's success and there is no better or speedier method of bringing about that change than education by the practitioner in the home and in the clinic. I do not think it is altogether unjust to accuse the medical profession of having pushed the dramatic and magical aspects of remedial medicine rather further than they deserve and of having drawn too little attention to the progress and importance of preventive measures. While we welcome the efforts which have been made in recent years to enlighten the public in matters of health more can yet be done, and done better.

REGIONAL ORGANISATION

We have been left in no doubt as to the intentions of the Government in regard to the coördination of hospital services after the war. The Minister of Health has adumbrated a scheme by which hospitals will be grouped together within regional areas for the purpose of providing remedial services for the whole population within those areas, controlled by an authority which has, so far, not been exactly determined but which, one may hope, will be carefully chosen, experienced and free from political influence. It is quite impossible to devise such a scheme successfully without taking into account the intimate relationship of hospital to other health services and particularly to those supplied by the general practitioner, an aspect of the problem which deserves more attention than it has hitherto received. May it not be that the interests of the community and of the profession would be best served by making regional authorities responsible for the coördination of all health services within their areas, under the general control of the Ministry of Health ? A wider scheme, such as this, would constitute a National Health Service with the advantages accruing from some degree of local elasticity and from some scope for experiment in the various regions concerned. A large body of professional opinion, which looks askance at a State Medical Service, may not be unwilling to accept a federal union of regional health services looking for general guidance and support from the state. Under such a system the problems confronting each regional health authority would vary in accordance with the size, character, distribution and occupations of its community, but the ultimate object of its activities would always be the good health of the people entrusted to its care.

A regional health authority might well be able to solve more easily than any central authority two of the problems to which I have already paid some attention. In the first place, it could so organise the profession within its area that waste of time and energy and money could be avoided by means of common clinics and common services, by the provision of consulting-rooms attached to hospitals and of ample pay-bed accommodation where it is especially needed. In the second place, it could promote in every way a complete working alliance of the public health officers with the general practitioners so that environmental and personal hygiene would eventually become the mutual object of the combined forces fighting in the cause of preventive medicine.

* * *

It is not for a physician, much less for a Harveian orator, to indicate or discuss the financial issues raised by the reorganisation of our health services. These are the concern of the public for whose benefit the services

are designed. On the other hand, I may be allowed to emphasise the folly of false economy when dealing with the conservation of the nation's most valuable asset. In various ways our modern so-called civilised state is content to destroy with one hand the health which it is at pains to promote with the other. It ignores, for instance, the teachings of science in the sphere of genetics; it does not hesitate to throw its best breeding stock into the furnace of war, and it spares no effort to foster the unfit at the expense of the fit. Is it too much to ask in return that those who survive the results of this racial ruin may be served by a profession sufficiently well subsidised to attract its due share of the best brains in the country? Reconstruction with second- or third-class material is rarely or never profitable in any field; reconstruction in medicine under such conditions would endanger the whole future of the social state if not of the race itself.

One final word. The changes in the organisation of the profession which are here suggested, if agreed upon, must be based on changes in the education of medical students and on intensified study of the social factors underlying the health of the nation. Prevention is better than cure.

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